

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Printed: 05/20/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175385	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/20/2015
NAME OF PROVIDER OR SUPPLIER ASBURY PARK			STREET ADDRESS, CITY, STATE, ZIP CODE 200 SW 14TH NEWTON, KS 67114		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 000	INITIAL COMMENTS	F 000			
F 280 SS=D	<p>The following citations represent the findings of complaint investigation #86456.</p> <p>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP</p> <p>The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>This Requirement is not met as evidenced by: The facility reported a census of 48 residents with 4 sampled for accidents. Based on observation, interview and record review, the facility failed to review and revise the plan of care to include the use of positioning devices in bed for 2 of the 4 resident's sampled (#1 and #3) related to the use of transfer bars.</p> <p>Findings included:</p> <p>- The Physician ' s Order Sheet, dated 3/25/15,</p>	F 280			
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE			TITLE		(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients . (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 280	<p>Continued From page 1</p> <p>documented resident #1 re-admitted to the facility on 3/18/14.</p> <p>The Significant Change Minimum Data Set (MDS), dated 4/28/15, documented the resident was rarely/never understood or made decisions and with severely impaired cognition per staff assessment. The resident required extensive assistance of 2 staff for bed mobility and was totally dependent on 2 staff for transfers, experienced one fall with a non-major injury since re-admission and bed rails were not used.</p> <p>The Care Area Assessment, dated 4/28/15, for Activities of Daily Living (ADLs) documented the resident returned to the facility on 4/22/15 and was admitted to hospice the same day. He/She is now actively dying, is bed bound and requires turning and repositioning routinely by nursing and hospice staff. The resident experienced a fall on 4/24/15 out of bed in which he/she obtained an abrasion. The resident is non-verbal and not able to make needs known due to the actively dying status.</p> <p>The initial nursing assessment for Hospice, dated 4/22/15 at 5:57 PM, documented the resident readmitted to the facility from a short hospital stay on Hospice with comfort care. The resident is bed bound and required complete assistance with all ADL ' s.</p> <p>The care plan, dated 3/3/15 and updated on 3/20/14 for 1-2 staff to assist for bed mobility; updated on 5/14/14 for staff to provide frequent observation while the resident was in bed; updated on 3/6/15 to provide a floor mat beside the bed while the resident was in bed; update on 4/22/15 that the resident was admitted to hospice; and updated on 4/27/15 that hospice provided a</p>	F 280			

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F 280	<p>Continued From page 2</p> <p>hi-low bed with ½ bed rails [transfer bar] for mobility and a hospice mattress. The care plan lacked identification for use of the transfer bar prior to the resident ' s fall out of the bed on 4/24/15.</p> <p>The nurse ' s note, dated 4/24/15 at 9:26 PM documented the resident was observed by staff in a compromised position on his/her hands and knees on the mat beside the bed, toward the head of the bed, which was in low position with his/her head and neck held in place by the device (transfer bar) used to enter and exit the bed on the right side of the bed. The resident had faint reddened areas to the upper chest.</p> <p>The Evaluation of Side Rail Usage, dated 5/7/15 (13 days after the incident and change of the style of bed and side rails), documented in the " recommendations " section that no side rails/transfer bars are indicated because the resident is immobile and does not make any attempt to exit or does not lean to one side.</p> <p>On 5/13/15 at 10:24 AM, Administrative Nursing Staff A confirmed that the resident continued to have a transfer bar used on the bed after the assessment, dated 5/7/15, which documented the device was not indicated for this resident. Staff A further stated that the facility had only assessed the use of these devices on admission or re-admission of a resident to the facility and did not re-assess the appropriateness or safety of the siderails/transfer bars when there was a change of the bed, the mattress, or the type of siderail/transfer bar or if the resident ' s condition had changed.</p> <p>On 5/13/15 at 12:32 PM, Licensed Nursing Staff C reported side rail/transfer bar assessments are</p>	F 280			

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F 280	<p>Continued From page 3</p> <p>done on admission, within the first 24 hours, and should be done again if there is a change in the resident ' s condition especially with mobility. Staff C stated they had never really been taught anything about these assessments, as far as how to use it to determine if the answers mean to use or not use the device. Staff C felt it was difficult to decipher that from the questions that are on the assessment. Staff C reported the assessment had an interventions section, with check box options that include one for if the resident will use the device or not, but that isn ' t always checked off by the nurses, even if the devices are used. The use of these devices should be identified on the care plan, in the mobility, safety or ADLs section.</p> <p>The facility failed to review and revise the plan of care to include the use of the transfer bar for this resident to ensure consistency of care.</p> <p>- The Physician ' s Order Sheet, dated 4/21/15, documented resident #3 admitted to the facility on 3/18/14.</p> <p>The annual Minimum Data Set (MDS), dated 1/20/15, documented the residents Brief Interview for Mental Status (BIMS) score of 11, indicating moderately impaired cognition, required extensive assist of 1 staff for bed mobility and transfers and bed rails were not used.</p> <p>The Care Area Assessment for Activities of Daily Living (ADLs), dated 1/20/15, documented the resident required assist of limited to extensive assist, had a history of falls, a history of a stroke with right-sided effects, and impaired decision making.</p>	F 280			

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F 280	<p>Continued From page 4</p> <p>The quarterly MDS, dated 4/14/15, documented the resident BIMS score of 09, indicating moderately impaired cognition and no other changes from the previous assessment.</p> <p>The care plan, last updated 4/21/15, documented the resident required 1-2 staff assist for bed mobility and transfers, had a floor mat beside the bed when in bed and lacked identification of side rail/transfer bar use.</p> <p>The Evaluation of Side Rail Usage, dated 4/7/15, documented the resident preferred 2 side rails and had a history of falls. The Nursing interventions section and recommendations section of the assessment were blank.</p> <p>Observation of the resident's room, on 5/13/15 at 9:02 AM, revealed the resident with a high/low bed and a hook style side transfer bar on the exit side of the bed with the other side of the bed against the wall.</p> <p>On 5/13/15 at 10:11 AM, Direct Care Staff D reported the resident did use the side rail on the bed and required assist of 1 staff to safely move in bed and to transfer from the bed. The resident cannot safely get in and out of bed independently, is too forgetful to call for help, and is a fall risk.</p> <p>On 5/13/15 at 12:32 PM, Licensed Nursing Staff C reported side rail assessments are done on admission, within the first 24 hours, and should be done again if there is a change in the resident's condition especially with mobility. Staff C stated they had never really been taught anything about the siderail/transfer bar assessment, as far as how to use it to determine if the answers mean to use or not use the device. Staff C felt it was difficult to decipher that from the questions that</p>	F 280			

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F 280	Continued From page 5 are on the assessment. The use of these devices should be identified on the care plan, in the mobility, safety or ADLs section. On 5/13/15 at 3:12 PM, Direct Care Staff E reported the resident had a transfer bar and did not use the device to reposition when lying in the bed. Staff E stated the resident required 2 staff assist for mobility and transfers. The facility failed to review and revise the plan of care to include the use of the transfer bar by this resident to ensure consistency of care.	F 280			
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This Requirement is not met as evidenced by: The facility reported a census of 48 residents with 4 sampled for accidents. Based on observation, interview and record review, the facility failed to ensure 2 of the 4 resident's sampled (#1 and #3) remained free of accidents related to the improper fitting of positioning devices (transfer bars) on their beds. Findings included: - The Physician 's Order Sheet, dated 3/25/15, documented resident #1 re-admitted to the facility on 3/18/14.	F 323			

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F 323	<p>Continued From page 6</p> <p>The Significant Change Minimum Data Set (MDS), dated 4/28/15, documented the resident was rarely/never understood or made decisions and with severely impaired cognition per staff assessment. The resident required extensive assistance of 2 staff for bed mobility and was totally dependent on 2 staff for transfers, experienced one fall with a non-major injury since re-admission and bed rails were not used.</p> <p>The Care Area Assessment, dated 4/28/15, for Activities of Daily Living (ADLs) documented the resident returned to the facility on 4/22/15 and was admitted to hospice the same day. He/She is now actively dying, is bedbound and requires turning and repositioning routinely by nursing and hospice staff. The resident experienced a fall on 4/24/15 out of bed in which he/she obtained an abrasion. The resident is non-verbal and not able to make needs known due to the actively dying status.</p> <p>The initial nursing assessment for Hospice, dated 4/22/15 at 5:57 PM, documented the resident readmitted to the facility from a short hospital stay on Hospice with comfort care. The resident is bed bound and required complete assistance with all ADL ' s.</p> <p>The care plan, dated 3/3/15 and updated on 3/20/14 for 1-2 staff to assist for bed mobility; updated on 5/14/14 for staff to provide frequent observation while the resident was in bed; updated on 3/6/15 to provide a floor mat beside the bed while the resident was in bed; update on 4/22/15 that the resident was admitted to hospice; and updated on 4/27/15 that hospice provided a hi-low bed with ½ bed rails [transfer bar] for mobility and a hospice mattress. The care plan lacked identification for use of the transfer bar</p>	F 323			

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F 323	<p>Continued From page 7</p> <p>prior to the resident ' s fall out of the bed on 4/24/15.</p> <p>The nurse ' s note, dated 4/24/15 at 9:26 PM documented the resident was observed by staff in a compromised position on his/her hands and knees on the mat beside the bed, toward the head of the bed, which was in low position with his/her head and neck held in place by the device (transfer bar) used to enter and exit the bed on the right side of the bed. The resident had faint reddened areas to the upper chest.</p> <p>The Evaluation of Side Rail Usage, dated 5/7/15 (13 days after the incident and change of the style of bed and side rails), documented in the " recommendations " section that no side rails/transfer bars are indicated because the resident is immobile and does not make any attempt to exit or does not lean to one side.</p> <p>On 5/13/15 at 10:24 AM, Administrative Nursing Staff A confirmed that the resident continued to have a transfer bar used on the bed after the assessment, dated 5/7/15, which documented the device was not indicated for this resident. Staff A further stated that the facility had only assessed the use of these devices on admission or re-admission of a resident to the facility and did not re-assess the appropriateness or safety of the siderails/transfer bars when there was a change of the bed, the mattress, or the type of siderail/transfer bar or if the resident ' s condition had changed.</p> <p>On 5/13/15 at 10:11 AM, Direct Care Staff D reported the resident required a full lift with the hoyer for transfers and suffered from dementia which kept the resident confused 100% of the time. Staff D reported on arrival to work at</p>	F 323			

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F 323	<p>Continued From page 8</p> <p>6:00AM, the resident would occasionally be lying at an angle in the bed, with feet dangling off the edge of the bed. The resident was in a low bed with a mat next to the bed on the floor and had a hook style side rail (a hand rail shaped like an upside down " U " that is affixed to the bed frame toward the head of the bed used for transfers and positioning in bed) with an air mattress on the bed. Staff D recalled that the resident did not use the bar independently, but would hold it during cares if staff cued the resident to do so. Staff D stated the hook style bars usually have lots of room between the bar and the mattress, somewhere between 4-5 inches. After the resident slid out of the bed, on 4/22/15, facility staff changed out the bed and transfer bar to a different style that fit snug against the mattress. In fact, it was so snug, it was hard to raise and lower the rail on the bed because it would rub up against the air mattress.</p> <p>On 5/13/15 at 12:32 PM, Licensed Nursing Staff C reported side rail/transfer bar assessments are done on admission, within the first 24 hours, and should be done again if there is a change in the resident ' s condition especially with mobility. Staff C stated they had never really been taught anything about these assessments, as far as how to use it to determine if the answers mean to use or not use the device. Staff C felt it was difficult to decipher that from the questions that are on the assessment. Staff C reported the assessment had an interventions section, with check box options that include one for if the resident will use the device or not, but that isn ' t always checked off by the nurses, even if the devices are used. The use of these devices should be identified on the care plan, in the mobility, safety or ADLs section. Staff C was not aware of the measurement that is required to determine if a</p>	F 323			

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F 323	<p>Continued From page 9</p> <p>siderail/transfer bar is safe. Staff C had never measured the fit of the device and the mattress for safety. When the resident re-admitted to the facility, he/she did not move around much and did not use the transfer bar. He/She was totally dependent on staff mobility in bed. Staff C stated the resident did not need the device because he/she could not have used them to turn his/herself. Staff C reviewed the resident ' s undated siderail/transfer bar assessment, and stated he/she could not tell if the resident was supposed to have a device or not.</p> <p>On 5/13/15 at 3:12 PM, Direct Care Staff E reported the resident was totally dependent on 2 staff for bed mobility and transfers. The resident had a hook style hand rail (transfer bar) when he/she re-admitted to the facility from the hospital on hospice. Staff E stated the resident did not use the device independently. The resident fell out of the bed, which was in the low position and his/her head was found against the transfer bar.</p> <p>On 5/14/15 at 12:48 PM, Administrative Nursing Staff A confirmed that the resident's 1st side rail/transfer bar assessment was not dated or completed by the staff, thereby it was unknown whether the resident was really appropriate for use of the device or not. When the resident was found, his/her head was found between the rail and the edge of the mattress because there was too much room. Staff A did not get a measurement of how big that space was on the resident ' s bed, nor did any of the staff. Staff confirmed the siderail/transfer bar assessments on the residents in the facility were not being consistently filled out by the nursing staff, stating he/she believed there was a system problem with assessing and use of the side rails/transfer bars.</p>	F 323			

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F 323	<p>Continued From page 10</p> <p>The facility lacked a policy addressing the use of siderails/transfer bars.</p> <p>The facility failed to thoroughly assess the appropriateness and safety for use of the transfer bar for this resident, who slid out of bed and whose head was found in the gap between the transfer bar and the mattress.</p> <p>- The Physician ' s Order Sheet, dated 4/21/15, documented resident #3 admitted to the facility on 3/18/14.</p> <p>The annual Minimum Data Set (MDS), dated 1/20/15, documented the residents Brief Interview for Mental Status (BIMS) score of 11, indicating moderately impaired cognition, required extensive assist of 1 staff for bed mobility and transfers and bed rails were not used.</p> <p>The Care Area Assessment for Activities of Daily Living (ADLs), dated 1/20/15, documented the resident required assist of limited to extensive assist, had a history of falls, a history of a stroke with right-sided effects, and impaired decision making.</p> <p>The quarterly MDS, dated 4/14/15, documented the resident BIMS score of 09, indicating moderately impaired cognition and no other changes from the previous assessment.</p> <p>The care plan, last updated 4/21/15, documented the resident required 1-2 staff assist for bed mobility and transfers, had a floor mat beside the bed when in bed and lacked identification of side rail/transfer bar use.</p> <p>The Evaluation of Side Rail Usage, dated 4/7/15,</p>	F 323			

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F 323	<p>Continued From page 11</p> <p>documented the resident preferred 2 side rails and had a history of falls. The Nursing interventions section and recommendations section of the assessment were blank.</p> <p>Observation of the resident's room, on 5/13/15 at 9:02 AM, revealed the resident with a high/low bed and a hook style side transfer bar on the exit side of the bed with the other side of the bed against the wall. At 11:48 AM, the space between the hand rail and the edge of the mattress was measured to be 5 1/2 inches. This was confirmed with Administrative Nursing Staff A and Administrative Nursing Staff B present. Staff A confirmed, at this time, the safe measurement is a maximum of 4 3/4 inches for this space, which was 3/4 of an inch less than the resident ' s bed currently measured.</p> <p>On 5/13/15 at 10:11 AM, Direct Care Staff D reported the resident did use the side rail on the bed and required assist of 1 staff to safely move in bed and to transfer from the bed. The resident cannot safely get in and out of bed independently, is too forgetful to call for help, and is a fall risk.</p> <p>On 5/13/15 at 12:32 PM, Licensed Nursing Staff C reported side rail assessments are done on admission, within the first 24 hours, and should be done again if there is a change in the resident ' s condition especially with mobility. Staff C stated they had never really been taught anything about the siderail/transfer bar assessment, as far as how to use it to determine if the answers mean to use or not use the device. Staff C felt it was difficult to decipher that from the questions that are on the assessment. The use of these devices should be identified on the care plan, in the mobility, safety or ADLs section. Staff C stated he/she was not aware of the measurement</p>	F 323			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175385	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/20/2015
NAME OF PROVIDER OR SUPPLIER ASBURY PARK			STREET ADDRESS, CITY, STATE, ZIP CODE 200 SW 14TH NEWTON, KS 67114		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 323	<p>Continued From page 12</p> <p>that is required to determine when a siderail/transfer bar is safe or not. Staff C had never measured the fit of the siderail/transfer bar and the mattress for safety. Staff C reported the resident will hold onto the transfer bar and help staff with positioning and care. The resident is a fall risk and cannot get out of bed independently.</p> <p>On 5/13/15 at 3:12 PM, Direct Care Staff E reported the resident had a transfer bar and did not use the device to reposition when lying in the bed. Staff E stated the resident required 2 staff assist for mobility and transfers.</p> <p>The facility lacked a policy addressing the use of siderails/transfer bars.</p> <p>The facility failed to assess the appropriateness and safety of use of the transfer bar for this resident, who was identified as a fall risk and was dependent on staff for mobility.</p>	F 323			